Division of TennCare

Health Care Innovation Initiative

Executive Summary

Back/Neck Pain Episode

Corresponds with DBR and Configuration file V3.0

Updated: January 2, 2020

OVERVIEW OF A BACK/NECK PAIN EPISODE

The back/neck pain episode pertains to patients who are diagnosed with back pain, neck pain, or a related diagnosis. For the purpose of this episode, related diagnoses refer to spine conditions such as sprains, degenerative and other disc disorders, disc displacement, radiculopathy, spondylosis, spondylolisthesis, stenosis, closed fractures, and pathological fractures. The trigger event is an office, outpatient hospital, or emergency department (ED) visit where the primary diagnosis indicates a back or neck pain, or related diagnosis. In addition, a visit where the primary diagnosis is a spine deformity with a secondary diagnosis code for back or neck pain is also a potential trigger event.

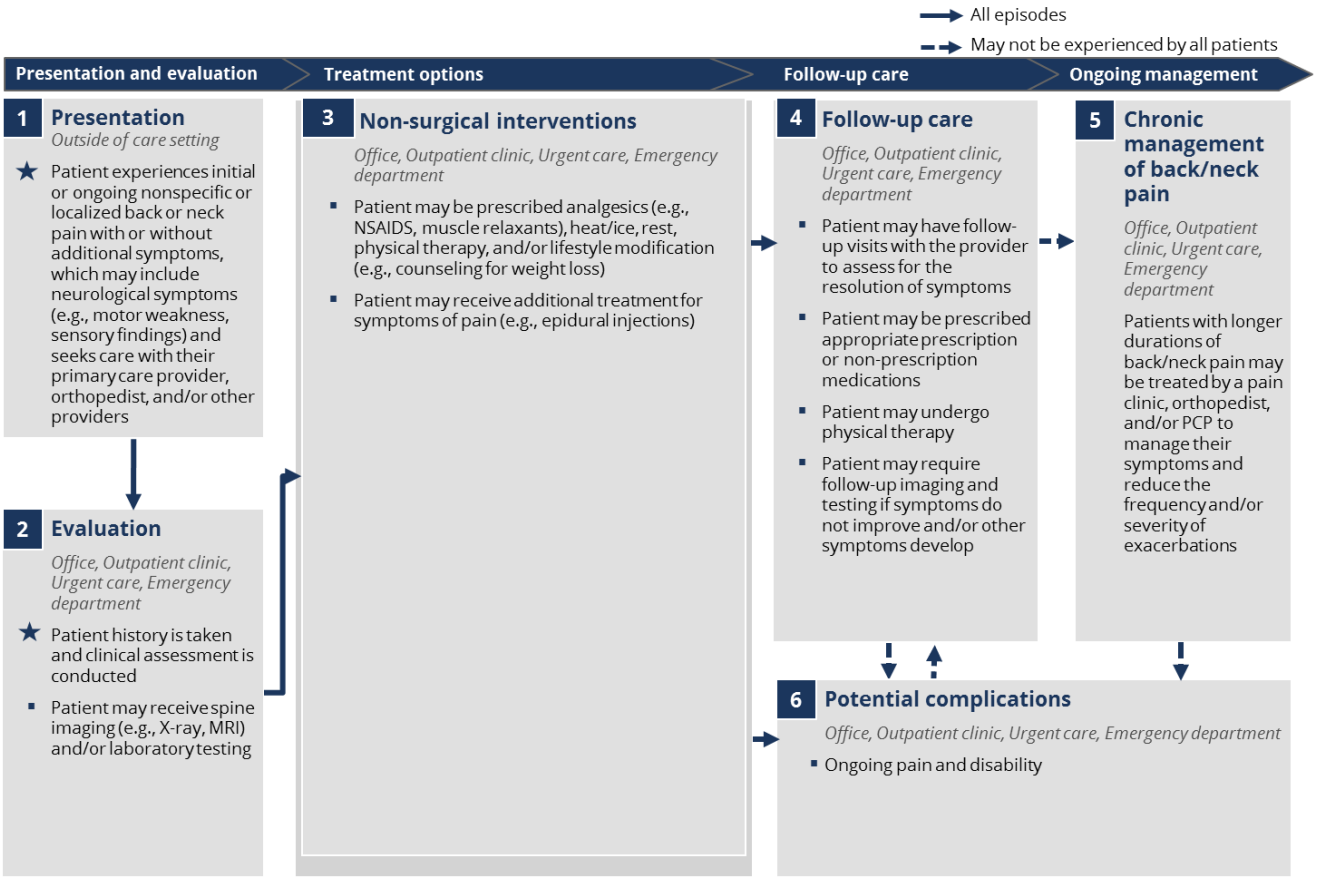
All related care – such as imaging and testing, surgical and medical procedures, and medications – is included in the episode. The quarterback, also called the principal accountable provider or PAP, is the clinician or group with the plurality of evaluation and management (E&M) visits for back or neck pain or related diagnoses during the episode window. The back/neck pain episode begins on the day of the triggering visit and ends 89 days after the triggering event.

CAPTURING SOURCES OF VALUE

In treating patients diagnosed with a back/neck pain or related diagnoses, providers have several opportunities to improve the quality and cost of care. Important sources of value include appropriate use of laboratory testing and imaging, evidence-based guidelines for pain management, and a coordinated multidisciplinary rehabilitation program. Other sources of value include appropriate use of prescription opioids, which may be associated with other complications such as addiction and overdose. Additionally, providers may increase efficiency and improve clinical outcomes through the appropriate use of non-surgical management and referral for surgical evaluation. Overall, these improvements may help to resolve patient symptoms, improve functionality, reduce potentially avoidable complications, and decrease costs.

To learn more about the episode's design, please reference the Detailed Business Requirements (DBR) and Configuration File on our website at https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/searchable-episodes-table.html.

Illustrative Patient Journey



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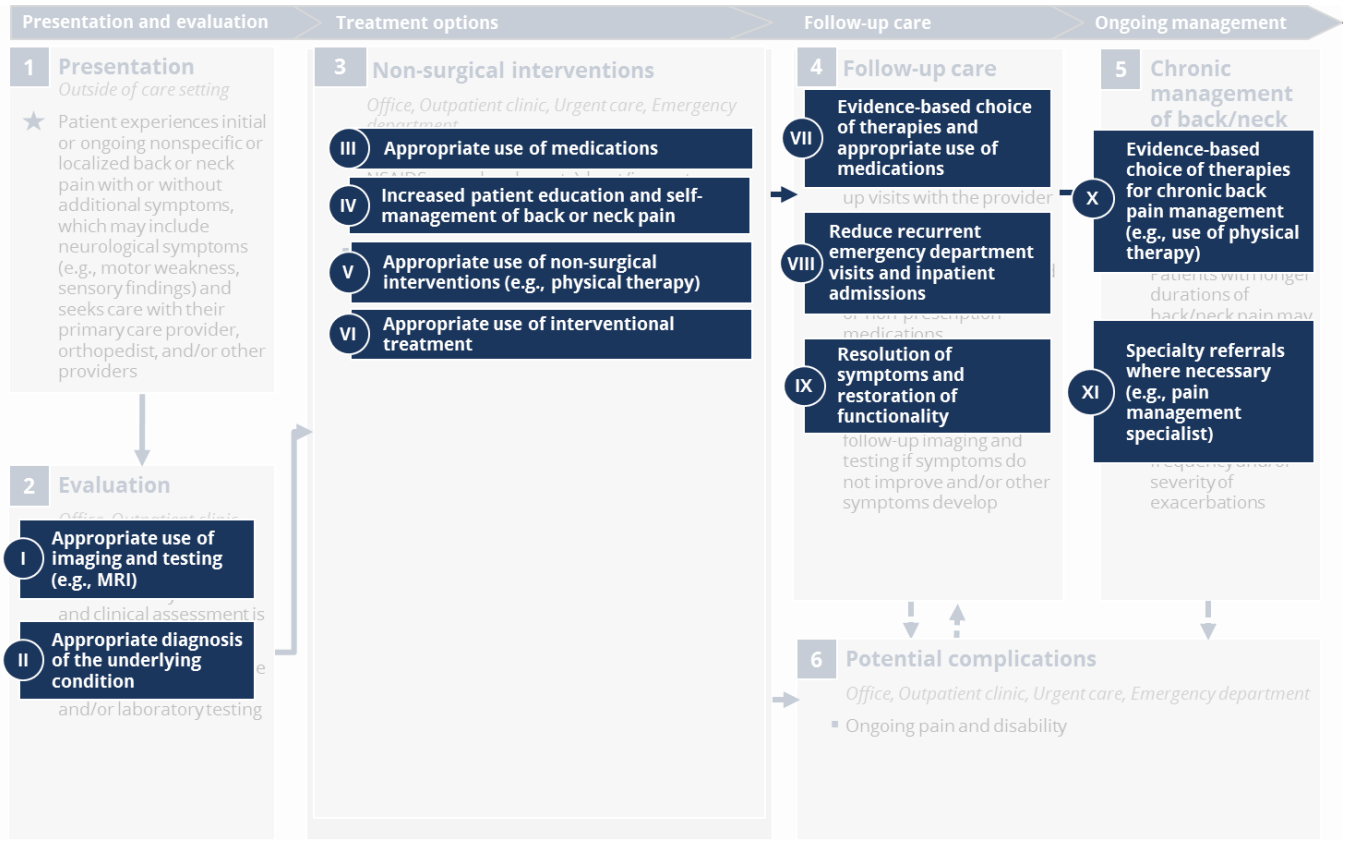
Potential Sources of Value



ASSIGNING ACCOUNTABILITY

The quarterback of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. To state it differently, the quarterback is the provider who has the greatest ability to influence all of the health care delivered in a given episode. For the back/neck pain episode, the quarterback is the clinician or group with the plurality of E&M visits for back or neck pain or related diagnoses during the episode window. The contracting entity or tax identification number of the professional trigger claim will be used to identify the quarterback.

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MAKING FAIR COMPARISONS

The episode model is designed to be fair to providers and incentivize best practices without penalizing providers who care for sicker patients. As such, important aspects of the model are:

- Inclusion of only the cost of services and medications that are related to the back/neck pain in calculation of episode spend.
- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete.
- Risk adjusting episode spend to account for the cost of more complicated patients.

The back/neck pain episode has no pre-trigger window. The trigger window includes care for specific diagnoses, related evaluation and management visits, specific imaging and testing, specific medications, and specific surgical and medical procedures. The back/neck pain episode has no post-trigger window.

Some exclusions apply to any type of episode, i.e., are not specific to a back/neck pain episode. For example, an episode would be excluded if more than one payer was involved in a single episode of care, if the patient was not continuously insured by the payer during the duration of the episode, or if the patient had a discharge status of 'left against medical advice'. Examples of exclusion criteria specific to the back/neck pain episode include patients with paralysis, active cancer, HIV, discitis, osteomyelitis, or ankylosing spondylitis. These patients have significantly different clinical courses that the episode does not attempt to risk adjust. Furthermore, there may be some factors with a low prevalence or significance that would make accurate risk adjustment difficult and may be used to exclude patients completely instead of adjusting their costs.

For the purposes of determining a quarterback's cost of each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk factors captured in recent claims data in order to be fair to providers caring for more complicated patients. Examples of patient factors likely to lead to the risk adjustment of a back/neck pain episode include anxiety, depression, chronic pain, chronic back or neck pain, or tobacco use. Over time, a payer may adjust risk factors based on new data.

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MEASURING QUALITY

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A quarterback must meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

The quality metric linked to gain sharing for the back/neck pain episode is:

- **Difference in Average MED[1]/day**: Average difference in morphine equivalent dose (MED)/day during the episode opioid window and the pre-trigger opioid window (lower value indicative of better performance)

The quality metrics that will be tracked and reported to providers but that are not tied to gain sharing are:

- **Average MED/day during the pre-trigger opioid window**: Average morphine equivalence dose (MED)/day during the 1-60 days prior to the trigger window (lower value indicative of better performance)
- **Average MED/day during the episode opioid window**: Average morphine equivalence dose (MED)/day during the episode window (lower value indicative of better performance)
- **Non-surgical management**: Percent of valid episodes with non-surgical management (e.g., physical therapy) during the episode window (rates provided for comparison only)
- **Absence of spine x-ray imaging**: Percent of valid low back pain episodes with no spine X-ray during the 29 days after diagnosis (higher rate indicative of better performance)
- **Absence of spine MRI imaging**: Percent of valid low back pain episodes with no spine MRI during the 29 days after diagnosis (higher rate indicative of better performance)

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[1] MED: morphine equivalent dose

- **Non-axial back/neck pain**: Percent of total (valid and invalid) episodes with neurologic involvement (rate not indicative of performance)
- **Drug screen**: Percent of valid episodes with a prescription filled for an opioid during the episode window that had a drug screening test during the episode window (higher rate indicative of better performance)
- **Opioid and benzodiazepine prescriptions**: Percentage of valid episodes with both an opioid prescription and a benzodiazepine prescription filled during the trigger window (lower rate indicative of better performance)

It is important to note that quality metrics are calculated by each payer on a per quarterback basis across all of a quarterback's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a quarterback ineligible for gain sharing with that payer for the performance period under review.